



## Designing Continuing Medical Education to Improve Clinician Practice Part 2: Writing the Needs Assessment

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Health care practitioners must participate in continuing education to maintain their licenses to practice. Accredited continuing medical education (CME) helps clinicians stay current on topics such as new clinical guidelines, regulations, and health policy that affect patient care.

CME providers must follow certain standards when creating accredited CME. These standards are outlined by the Accreditation Council for Continuing Medical Education (ACCME), the entity that puts its stamp of approval on providers of CME. Continuing medical education must (a) be related in some way to the work clinicians do by helping them practice more effectively or efficiently; and (b) fulfill a need for training to improve clinician competency. In other words, CME providers must first identify where clinicians' professional ability fails to meet best practice standards, then design CME that provides them with education that helps them elevate their level of competency.

To ensure that the instructional materials or activities we create meet these two requirements, we follow a process that guides the development of CME. In the last issue of the *AMWA Journal*, I discussed this process, called educational linkage, through which we connect (1) a documented deficiency in clinician performance or patient care; (2) the educational intervention; and (3) the direct benefits clinicians gain from participating in CME programs, such as enhanced knowledge or clinical skill, better attitudes, and improved practice performance. Ultimately, this results in improvement in health care outcomes. In Part 1 of this series, I discussed the first phase in writing a needs assessment (NA): how to identify gaps in practice and where to find information to document these gaps. (See *AMWA J. 2013; 28(1): 28-30*.) Here, in Part 2, I continue the discussion on writing NAs by describing how we pull together information from the gap analysis and assessment of needs to create a formal NA document. In future articles, I will discuss how, through educational linkage, this document is used to inform the program's educational objectives, content, and evaluation, as well as outcome studies to demonstrate the effectiveness of the CME.

### Reasons for Writing CME Needs Assessments (NA)

CME providers write NAs to provide documentation of the need for CME (fulfilling a requirement by ACCME), and to guide the development of the education program. In addition, NAs also are written to be included in grant proposals for commercial funding for CME as validation of the need for education.

CME providers have not developed a common template for NAs. However, there are specific types of information that are universally included. The result is a succinct report that describes the condition of interest and its epidemiology, compares how it is treated and managed with what guidelines recommend, and shows how CME can effectively change behavior of clinicians so that their practices are better aligned with best practice standards, with the goal of improving patient health outcomes.

An NA's length and format are shaped by the reason it is being written. For example, an NA that is written to fulfill the ACCME documentation requirement can consist of a bulleted list or a table, whereas an NA written for a grant proposal is formatted as a report in accordance with page limits and other requirements included in a grantor organization's request for proposals. Any way you write it, however, the information in an NA can be included in three main sections, as outlined below.

### Section 1: Introduction

- The purpose for writing the needs assessment
- Source of documentation
- Identification of the condition, disease, or clinical problem being addressed
  - Cause
  - Risk factors
- Definition of patient population affected by the condition, disease, or clinical problem
  - Demographics (eg, sex, age, ethnicity, and socioeconomic status)
  - Prevalence/incidence
  - Morbidity/mortality
- Description of effect of condition on society at large
  - Economic (eg, work days lost, health care costs)
  - Trends (predictions of impact if condition grows unchecked)

## Section 2: Best and Current Practice

- Description of best practice standards (the way clinicians should practice)
- Description of gap in clinician competency (the way clinicians currently practice)
- Description of barriers preventing best practice

## Section 3: CME as the Solution to Improve Current Practice

- Explanation of the value of CME
- Examples of how CME has been effective in changing clinician behavior

(For grant proposals, this last subtopic can provide a nice

lead-in to how the CME activity, for which funding is sought, has been designed to improve clinician competency.)

CME writers need to master the art of writing NAs. For many of us, NAs are the most common document we are hired to produce.

To provide you with an idea of how these three sections are written into an NA, the accompanying sidebar provides excerpts from an excellent sample NA written by a student in the CME Training for Medical Writers course I teach. (The sample is used with permission.) The annotation is mine.

## NEEDS ASSESSMENT: THE APPROPRIATE MANAGEMENT OF HYPERTENSION

### SECTION 1: INTRODUCTION

The goal of this needs assessment is to identify potential professional practice gaps in and barriers to the appropriate management of hypertension in the primary care setting. [PURPOSE]

Hypertension is increasingly being diagnosed in both older and younger individuals, and the rate of uncontrolled hypertension is suboptimal. [CONDITION IDENTIFIED]

Clinical practice guidelines, results from physician and patient surveys, government reports, and systematic reviews of the current literature were used to document gaps and barriers. [SOURCES]

Hypertension is prevalent, affecting 31% of the US population.<sup>1</sup> Among adults 45 years and older, hypertension is the number one diagnosis at visits to office-based physicians and hospital outpatient departments.<sup>2</sup> [PREVALENCE/INCIDENCE]

Individuals who are normotensive at age 55 have a 90% lifetime risk for the condition, which means that as a large proportion of the US population continues to age, hypertension will become an even greater problem.<sup>3</sup> [RISK; TRENDS]

In addition, the rate of hypertension among younger individuals (24–32 years) has recently been found to be higher (19%) than previously estimated (4%).<sup>4</sup> [INCIDENCE/PREVALENCE]

Hypertension is associated with considerable morbidity and mortality and is a major risk factor for cardiovascular disease and stroke. Hypertension is the cause of death in 1 of every 7 deaths in the United States<sup>1</sup> and accounts for nearly half of all cardiovascular disease-related deaths.<sup>3</sup> [MORBIDITY/MORTALITY; RISK]

Hypertension also places huge economic demands on an already-overburdened health care system, with the American Heart Association estimating that the direct and indirect costs of hypertension are more than \$93.5 billion per year.<sup>5</sup> [EFFECT ON SOCIETY]

### SECTION 2: BEST PRACTICE, CURRENT PRACTICE, AND BARRIERS

A complicating feature of hypertension is that 46% of individuals with the condition have uncontrolled blood pressure—that is, a blood pressure above the recommended goal established by the Seventh Report of the Joint National Committee on the Preven-

tion, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7).<sup>1,3</sup>

Controlling hypertension according to evidence-based guidelines involves identifying hypertension as a diagnosis, selecting the most effective drug therapy, and routinely monitoring blood pressure and adjusting medications to achieve a target blood pressure. [BEST PRACTICE]

The JNC 7 defines hypertension as blood pressure of 140/90 mm Hg or more and recommends monitoring blood pressure at approximately monthly intervals until a blood pressure below the hypertension limit is reached.<sup>3</sup> [BEST PRACTICE]

Furthermore, the JNC 7 recommends that a thiazide-type diuretic should be initial therapy for hypertension and advises that more than one antihypertensive agent is usually required to control blood pressure, and that drug therapy should be intensified if the blood pressure goal has not been reached.<sup>3</sup> [BEST PRACTICE]

Physicians report a high rate (94%) of familiarity with the JNC 7 guidelines, and the appropriate treatment of hypertension according to JNC 7 guidelines increased shortly after their dissemination but was not sustained beyond a few years.<sup>7,8</sup> [CURRENT PRACTICE]

Subsequent research has shown that treatment with fixed-dose combination medications is more effective than the use of single agents given together and enhances patient compliance as well.<sup>9,10</sup> [BEST PRACTICE] However, the use of fixed-dose combinations is underutilized.<sup>9</sup> [CURRENT PRACTICE]

The approximate 50% rate of controlled hypertension indicates that physicians are not adhering to the JNC 7 for appropriate treatment interventions. The reasons for this lack of adherence are unclear, but many factors have been found to control and influence the severity of hypertension.<sup>11</sup> [CURRENT PRACTICE]

Clinical inertia has been identified as the primary barrier to controlling hypertension through adjustment of drug therapy, with one study showing clinical inertia as the reason 63% of patients with uncontrolled hypertension did not have their medications changed.<sup>12</sup> In that study, several factors were found to be predictors of no medication change, including diabetes as comorbidity, a blood pressure that was less than 10 mm Hg away from target, a patient load of more than 26 per day, and patient

ethnicity (non-Hispanic white).<sup>12</sup> [CURRENT PRACTICE/BARRIER TO BEST PRACTICE]

Other studies have also shown that a blood pressure within 5 to 10 mm Hg of target was less likely to prompt a medication change.<sup>13</sup> In addition, physicians have reported such other reasons as using a “wait until next visit” approach before intensifying medical therapy,<sup>14</sup> inadequate time to discuss hypertension management with their patients, patient-related factors (lack of compliance with drug therapy and/or follow-up visits), and staff-related factors (inaccurate blood pressure measurements).<sup>7</sup>

[CURRENT PRACTICE/BARRIER TO BEST PRACTICE]

Patient-related factors have been documented in several studies as major contributors to uncontrolled hypertension, which means that improving rates of control relies on strategies to motivate patients to adhere to medical therapy and lifestyle modifications as well as to appropriate follow-up.<sup>15</sup> [BARRIER TO BEST PRACTICE]

### SECTION 3: CME AS SOLUTION

Controlling hypertension requires a comprehensive approach, with improvements needed in health care delivery systems, physician behavior and practice, and patient adherence to prescribed treatment.<sup>1</sup> Continuing medical education (CME) provides clinicians with an excellent opportunity to review guidelines and to learn new strategies for treatment and management. [VALUE OF CME]

Several strategies have been successful in improving hypertension control,<sup>16</sup> and interactive CME programs have been shown to change physician behavior with respect to the appropriate management of hypertension through implementation of these strategies.<sup>17</sup> [CME IS EFFECTIVE.]

CME activities that focus on evidence-based strategies can improve control and, ultimately, reduce the morbidity and mortality associated with hypertension.<sup>18</sup> [CME IS EFFECTIVE.]

Because of the lack of patient adherence to antihypertension drug therapy, CME activities that highlight documented interventions that enhance patient compliance and patient education can help physicians implement strategies that will better engage patients in self-management, leading to improved rates of control and better patient outcomes.<sup>19</sup> [CME IS EFFECTIVE.]

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